FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042549

Facility Name: RIVER PARK HEALTHCARE CENTER

Address: 2545 24th ST (Number) ROCK ISLAND (City) 61201 (Zip Code)

County: WILL

Telephone Number: (847) 647-1717 **Fax #** (847) 647-0222

IDPA ID Number: 36-4127168

Date of Initial License for Current Owners: 03/06/97

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) SHERWIN I. RAY
(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA/PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1
(Telephone) (847) 675-3585 Fax (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Print Preview

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 06/01/99

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	177	Skilled (SNF)	177	64,782	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	177	TOTALS	177	64,782	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,024	1,657	3,167	12,849	8
9	SNF/PED					9
10	ICF	36,556	5,248		41,803	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,580	6,905	3,167	54,652	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 84.36%

D. How many bed-hold days during this year were paid by Public Aid? 214 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/06/97

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/06/97 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 26 and days of care provided 3167

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number RIVER PARK HEALTHCARE CENTE # 0042549 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	144,587	15,357	7,748	167,692		167,692	(4,950)	162,742			1
2	Food Purchase		204,276		204,276	(11,968)	192,308	(1,365)	190,943			2
3	Housekeeping	135,371	21,951	0	157,322		157,322	0	157,322			3
4	Laundry	58,624	21,184	0	79,808		79,808	0	79,808			4
5	Heat and Other Utilities			117,845	117,845		117,845	451	118,296			5
6	Maintenance	46,306	29,581	24,351	100,238		100,238	13,572	113,810			6
7	Other (specify):*			9,532	9,532		9,532	0	9,532			7
8	**TOTAL General Services**	384,888	292,349	159,476	836,713	(11,968)	824,745	7,708	832,453			8
	B. Health Care and Programs											
9	Medical Director			16,800	16,800		16,800	0	16,800			9
10	Nursing and Medical Records	1,200,746	83,879	2,579	1,287,204		1,287,204	26,070	1,313,274			10
10a	Therapy	138,010	3,167	38,460	179,637		179,637	(4,329)	175,308			10a
11	Activities	75,656	4,664	569	80,889		80,889	0	80,889			11
12	Social Services	58,330		3,672	62,002		62,002	0	62,002			12
13	Nurse Aide Training			0				0				13
14	Program Transportation			30	30		30	0	30			14
15	Other (specify):*							0				15
16	**TOTAL Health Care and Progra**	1,472,742	91,710	62,110	1,626,562		1,626,562	21,741	1,648,303			16
	C. General Administration											
17	Administrative	98,529		147,000	245,529		245,529	(44,502)	201,027			17
18	Directors Fees			0				0				18
19	Professional Services			174,633	174,633		174,633	(128,351)	46,282			19
20	Dues, Fees, Subscriptions & Promotions			12,742	12,742		12,742	(64)	12,678			20
21	Clerical & General Office Expense	94,062	11,198	107,657	212,917		212,917	(46,045)	166,872			21
22	Employee Benefits & Payroll Taxes			267,316	267,316	11,968	279,284	0	279,284			22
23	Inservice Training & Education			1,056	1,056		1,056	1,058	2,114			23
24	Travel and Seminar			6,972	6,972		6,972	117	7,089			24
25	Other Admin. Staff Transportation			11,828	11,828		11,828	1,335	13,163			25
26	Insurance-Prop.Liab.Malpractice			85,501	85,501		85,501	3,970	89,471			26
27	Other (specify):*			0				27,640	27,640			27
28	**TOTAL General Administration**	192,591	11,198	814,705	1,018,494	11,968	1,030,462	(184,842)	845,620			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,050,221	395,257	1,036,291	3,481,769		3,481,769	(155,393)	3,326,376			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number RIVER PARK HEALTHCARE CENTE # 0042549 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			22,043	22,043		22,043	114,892	136,935			30
31	Amortization of Pre-Op. & Org.			1,662	1,662		1,662	0	1,662			31
32	Interest			3,198	3,198		3,198	394,798	397,996			32
33	Real Estate Taxes			120,314	120,314		120,314	0	120,314			33
34	Rent-Facility & Grounds			507,000	507,000		507,000	(500,995)	6,005			34
35	Rent-Equipment & Vehicles			32,438	32,438		32,438	(7,979)	24,459			35
36	Other (specify):*							0				36
37	TOTAL Ownership			686,655	686,655		686,655	716	687,371			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		107,296	114,843	222,139		222,139	(35,089)	187,050			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			97,174	97,174		97,174	0	97,174			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		107,296	212,017	319,313		319,313	(35,089)	284,224			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,050,221	502,553	1,934,963	4,487,737	0	4,487,737	(189,766)	4,297,971			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(9,651)	30		9
10	Interest and Other Investment Income	(3,198)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,365)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,935)	21		18
19	Entertainment				19
20	Contributions	(207)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(653)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(326)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(813)	20		28
29	Other-Attach Schedule SEE PG 5A	(28,485)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (46,633)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(143,133)		34
35	Other- Attach Schedule	0		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (143,133)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (189,766)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Preview

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34	RIVER PARK HEALTHCARE CENTER		
35			
36			
37			
38	PG 5 LINE 29 - DEFERRED MAINTENANCE XI	618	6
39	MARKETING SALARIES	(29,103)	21
40			
41			
42			

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Numb RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	(4,950)	0	0	0	0	0	0	0	0	0	(4,950)	1
2	Food Purchase	(1,365)	0	0	0	0	0	0	0	0	0	0	(1,365)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	451	0	0	0	0	0	0	0	0	0	451	5
6	Maintenance	618	12,954	0	0	0	0	0	0	0	0	0	13,572	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(747)	8,455	0	0	0	0	0	0	0	0	0	7,708	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	26,070	0	0	0	0	0	0	0	0	0	26,070	10
10a	Therapy	0	6,970	(11,299)	0	0	0	0	0	0	0	0	(4,329)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Program**	0	33,040	(11,299)	0	0	0	0	0	0	0	0	21,741	16
	C. General Administration													
17	Administrative	0	(44,502)	0	0	0	0	0	0	0	0	0	(44,502)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(653)	(127,698)	0	0	0	0	0	0	0	0	0	(128,351)	19
20	Fees, Subscriptions & Promotions	(1,346)	0	1,282	0	0	0	0	0	0	0	0	(64)	20
21	Clerical & General Office Expenses	(31,038)	(77,880)	62,873	0	0	0	0	0	0	0	0	(46,045)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	1,058	0	0	0	0	0	0	0	0	1,058	23
24	Travel and Seminar	0	0	117	0	0	0	0	0	0	0	0	117	24
25	Other Admin. Staff Transportation	0	0	1,335	0	0	0	0	0	0	0	0	1,335	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,970	0	0	0	0	0	0	0	0	3,970	26
27	Other (specify):*	0	0	27,640	0	0	0	0	0	0	0	0	27,640	27
28	**TOTAL General Administration**	(33,037)	(250,080)	98,275	0	0	0	0	0	0	0	0	(184,842)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(33,784)	(208,585)	86,976	0	0	0	0	0	0	0	0	(155,393)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Numb: RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(9,651)	0	124,543	0	0	0	0	0	0	0	0	114,892	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,198)	0	397,996	0	0	0	0	0	0	0	0	394,798	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(500,995)	0	0	0	0	0	0	0	0	(500,995)	34
35	Rent-Equipment & Vehicles	0	0	(7,979)	0	0	0	0	0	0	0	0	(7,979)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(12,849)	0	13,565	0	0	0	0	0	0	0	0	716	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	(35,089)	0	0	0	0	0	0	0	0	(35,089)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Cent**	0	0	(35,089)	0	0	0	0	0	0	0	0	(35,089)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(46,633)	(208,585)	65,452	0	0	0	0	0	0	0	0	(189,766)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Numbe RIVER PARK HEALTHCARE CENTEI # 0042549 Report Period Beginning 01/01/2000 Ending: 12/31/2000

Show Pgs 6A thru 6 | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				CAREPLUS MGMT	NILES	MGMT/CLERICAL
SEE ATTACHED SCHEDULES				CAREPLUS REHABILITATIVE SERVICES		
					NILES	THERAPY
				RIVER PARK HEALTHCARE CENTER LLC		
					NILES	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6
1 V	17	MANAGEMENT FEES	99,000	CAREPLUS MGMT INC	0	0	(99,000)	1	-99000
2 V	19	ADMIN. CONSULTANT FEES	132,000	" "			(132,000)	2	-132000
3 V	19	DATA PROCESSING FEES	8,800	" "			(8,800)	3	-8800
4 V	21	CLERICAL FEES	77,880	" "			(77,880)	4	-77880
5 V	1	DIETARY CONSULTANT FEE	4,950	" "			(4,950)	5	-4950
6 V	15	DIETARY SALARIES		" "		9,500	9,500	6	9500
7 V	5	ELECTRICITY		" "		451	451	7	451
8 V	6	REPAIRS		" "		796	796	8	796
9 V	6	MAINTENANCE SALARIES		" "		12,158	12,158	9	12158
10 V	10	NURSING		" "		26,070	26,070	10	26070
11 V	10a	THERAPY SALARIES		" "		6,970	6,970	11	6970
12 V	17	ADMIN SALARIES		" "		54,498	54,498	12	54498
13 V	19	PROFESSIONAL FEES		" "		3,602	3,602	13	3602
14 Total			322,630		0	114,045	(208,585)	14	

* Total must agree with the amount recorded on line 24 of Schedule V

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

Print Preview

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

Print Page 6A

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	20	DUES/LICENSES/WANT ADS	$	CAREPLUS MGMT INC		$ 1,282	$ 1,282	15	1282
16	V	21	OFFICE SALARIES/EXPENSES		" "		62,873	62,873	16	62873
17	V	23	SEMINARS		" "		1,058	1,058	17	1058
18	V	24	TRAVEL		" "		117	117	18	117
19	V	25	TRANSPORTATION		" "		1,335	1,335	19	1335
20	V	26	INSURANCE		" "		3,970	3,970	20	3970
21	V	27	EMPLOYEE BENEFITS		" "		27,640	27,640	21	27640
22	V	30	SL DEPRECIATION		" "		9,835	9,835	22	9835
23	V	32	INTEREST		" "		986	986	23	986
24	V	34	OFFICE RENT		" "		6,005	6,005	24	6005
25	V	35	EQUIP RENT/AUTO LEASE	15,475	" "		7,496	(7,979)	25	-7979
26	V								26	
27	V								27	
28	V								28	
29	V	10a	THERAPY SERVICES	38,460	CAREPLUS REHABILITATIVE SERVICES		27,161	(11,299)	29	-11299
30	V	39	ANCILLARY THERAPY	119,435	" "		84,346	(35,089)	30	-35089
31	V								31	
32	V								32	
33	V	34	RENT	507,000	RIVER PARK HEALTHCARE CENTER LLC			(507,000)	33	-507000
34	V	30	SL DEPRECIATION		" "		114,708	114,708	34	114708
35	V	32	INTEREST		" "		397,010	397,010	35	397010
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 680,370			$ 745,822	$ * 65,452	39	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Preview

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Print Page 6B

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STATE OF ILLINOIS

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6B

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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Print Page 6C

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Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6C

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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Print Page 6D

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STATE OF ILLINOIS

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Facility Name & ID Number RIVER PARK HEALTHCARE CENTI # 0042549 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATIONS:								$		1
2	SHERWIN RAY	PRESIDENT	ADMIN/FINAN	33.33	SEE ATTACHED	5.1	8.43	SALARY	15,587	17-7	2
3	JAKOB BAKST	DIR OPERAT'NS	ADMIN/CONS.	33.33	SCHEDULES	5.1	8.43	" "	15,587	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	ERIC ROTHNER (HUNTER MGMT LLC)		CONSULTING	33.33	" "	0.3	0.42	MGMT FEES	48,000	17-3	11
12											12
13								TOTAL	$ 79,174		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Print Preview

the name(s)
PORTS.

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D | Show Pgs 8E thru 8I | Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPLUS MANAGEMENT INC
Street Address: 5940 W TOUHY
City / State / Zip Code: NILES 60714
Phone Number: (847) 647-1717
Fax Number: (847) 647-0222

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	CENSUS DAYS	559,284	11	$ 97,227	$ 97,227	54,652	$ 9,500	1
2	5	ELECTRICITY	" "	648,651	14	5,352		54,652	451	2
3	6	REPAIRS	" "	648,651	14	9,448		54,652	796	3
4	6	MAINTENANCE SALARIES	" "	648,651	14	144,297	144,297	54,652	12,158	4
5	10	NURSING	" "	648,651	14	309,417	309,417	54,652	26,070	5
6	10a	THERAPY SALARIES	" "	578,314	12	73,756	73,756	54,652	6,970	6
7	17	ADMIN SALARIES	" "	648,651	14	646,825	646,825	54,652	54,498	7
8	19	PROFESSIONAL FEES	" "	648,651	14	42,748		54,652	3,602	8
9	20	DUES/LICENSES/WANT AD	" "	648,651	14	15,220		54,652	1,282	9
10	21	OFFICE SALARIES/EXPEN	" "	648,651	14	746,225	559,379	54,652	62,873	10
11	23	SEMINARS	" "	648,651	14	12,554		54,652	1,058	11
12	24	TRAVEL	" "	648,651	14	1,390		54,652	117	12
13	25	TRANSPORTATION	" "	648,651	14	15,846		54,652	1,335	13
14	26	INSURANCE	" "	648,651	14	47,123		54,652	3,970	14
15	27	EMPLOYEE BENEFITS	" "	648,651	14	328,053		54,652	27,640	15
16	30	SL DEPRECIATION	" "	648,651	14	116,734		54,652	9,835	16
17	32	INTEREST	" "	648,651	14	11,707		54,652	986	17
18	34	OFFICE RENT	" "	648,651	14	71,276		54,652	6,005	18
19	35	EQUIP RENT/AUTO LEASE	" "	648,651	14	88,968		54,652	7,496	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,784,166	$ 1,830,901		$ 236,642	25

Print Preview

Print Page 8A

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8B

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8C

STATE OF ILLINOIS

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8D

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Facility Name & ID Number RIVER PARK HEALTHCARE CENTE # 0042549 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	CAREPLUS MANAGEMENT ALLOCATION: LOC, ETC						$	$			$ 986	1
2												2
3	RELATED PARTY: RIVER PARK HEALTHCARE CENTER LLC											3
4	CIB BANK		X	MORTGAGE	$42,224.00	12/98	5,100,000	4,872,478	12/2004	7.75	389,055	4
5	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN	09/97	46,071	17,834			7,955	5
	Working Capital											
6												6
7	INSURANCE FINANCING		X	INSUR. FINANCE							3,198	7
8												8
9	TOTAL Facility Related				$42,224.00		$ 5,146,071	$ 4,890,312			$ 401,194	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,146,071	$ 4,890,312			$ 401,194	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Preview

Facility Name & ID Numbe RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	121,780	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	120,444	2
3. Under or (over) accrual (line 2 minus line 1).	$	(1,336)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	121,650	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	120,314	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	111,514	8
	1996	116,819	9
	1997	120,896	10
	1998	120,575	11
	1999	120,444	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Print Preview

Facility Name & ID Numb RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,494 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories 4 + BASEMENT

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 8,312 2. Number of Years Over Which it is Being Amortized: 5 YRS

3. Current Period Amortization: 1,662 4. Dates Incurred: 3/97

Nature of Costs: ORGANIZATION EXPENSE - LEGAL FEES

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	RELATED PARTY:RIVER PARK HEALTHCARE CENTER			$	1
2	NURSING HOME:	5.16 ACRES	1997	420,000	2
3	TOTALS	0		$ 420,000	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	RELATED PARTY: RIVER PARK HEALTHCARE CE				$	$		$	$	$	4
5	177		1997	1975	3,596,265	92,208	39	92,208		303,561	5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	FLOORING,WALLCOVER,WINDOW TREATMENTS,DOOR			1997	66,202	1,698	39	1,698		6,179	9
10	WINDOWS			1998	2,278	58	39	59	1	145	10
11	WALK-IN FREEZER COMPRESSOR			2000	2,097	67	27.5	67		67	11
12											12
13											13
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29											29
30											30
31											31
32											32
33											33
34	RELATED PARTY ALLOCATION - CAREPLUS MGMT					89		89			34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 94,120		$ 94,121	$ 1	$ 309,952	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Facility Name & ID Numbe RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12B

STATE OF ILLINOIS

Facility Name & ID Numbe RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12C

STATE OF ILLINOIS

Facility Name & ID Numbe RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12D

STATE OF ILLINOIS

Facility Name & ID Numbe RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 116,980	$ 15,232	$ 9,162	$ (6,070)	8-15 YRS	$ 26,303	37
38	Current Year Purchases	34,904	4,988	1,406	(3,582)	10-15 YRS	1,406	38
39	Fully Depreciated Assets							39
40	** RELATED PARTY - SL DEPN: CAREPLUS MGMT, 9,746 / RIVER PARK LLC, 22		32,246	32,246				40
41	TOTALS	$ 151,884	$ 52,466	$ 42,814	$ (9,652)		$ 27,709	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 146,586	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 136,935	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (9,651)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 337,661	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A -- RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. _____
   This amount was calculated by dividing the total amount to be amortized _____
   by the length of the lease _____.

9. Option to Buy: [ ] YES [ ] NO Terms: _____ *

10. Effective dates of current rental agreement:
    Beginning _____
    Ending _____

11. Rent to be paid in future years under the curre
    rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$ 714,174
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipm $ 24,638 Description: NURSING EQUIP: 1413 / WASHER DRYER: 7750 / COMPUTERS: 15475
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY VAN	'98 CHEVY EXPRESS	$ 650.00	$ 7,800	17
18					18
19					19
20					20
21	TOTAL		$ 650.00	$ 7,800	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Preview

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Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY TRAINED AIDES.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income y facility received training aides from other faciliti

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

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Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Cost	Outside Practitioner (other than consultant) Units	Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs		$		$ 54,835	$		$ 54,835	1
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	hrs				59,468			59,468	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39-2	# of prescrpts					59,984		59,984	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program	39-2 / 39-3					540	18,244		18,784	12
13	MED.SUPPLIES/RENTALS Other (specify):	39-2						29,068		29,068	13
14	TOTAL				$		$ 114,843	$ 107,296		$ 222,139	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	900,313		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	44,190		6
7	Other Prepaid Expenses	70,822		7
8	Accounts Receivable (owners or related parties)	67,810		8
9	Other(specify): SHORT TERM NOTE RECEIV	519,000		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,602,135	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	70,577		15
16	Equipment, at Historical Cost	151,885		16
17	Accumulated Depreciation (book methods)	(80,404)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	8,312		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(4,987)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DUE FROM LLC	84,981		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 230,364	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,832,499	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 414,077	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,062		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	80,429		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,635		31
32	Accrued Real Estate Taxes(Sch.IX-B)	121,650		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	COMPUTER LEASE	15,455		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 648,308	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 648,308	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,184,191	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,832,499	$	48

***(See instructions.)**

Print Preview

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 780,544	1
2	Restatements (describe):		2
3	POST-CLOSING EXPENSES	(18,387)	3
4	ROUNDING	3	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 762,160	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	846,831	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(424,800)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 422,031	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,184,191	24 *

*** This must agree with page 17, line 47.**

Print Preview

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,296,716	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,296,716	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	17,014	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 17,014	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thr**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	20,838	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and**	$ 20,838	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 2**	$ 5,334,568	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 836,713	31
32	Health Care	1,626,562	32
33	General Administration	1,018,494	33
	B. Capital Expense		
34	Ownership	686,655	34
	C. Ancillary Expense		
35	Special Cost Centers	222,139	35
36	Provider Participation Fee	97,174	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,487,737	40
41	**Income before Income Taxes (line 30 minus line 40)****	846,831	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus**	$ 846,831	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Print Preview

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,128	2,385	$ 55,359	$ 23.21	1
2	Assistant Director of Nursing	1,922	2,083	41,106	19.73	2
3	Registered Nurses	9,768	10,166	195,735	19.25	3
4	Licensed Practical Nurses	23,020	23,911	342,976	14.34	4
5	Nurse Aides & Orderlies	60,224	62,656	547,839	8.74	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	13,153	13,445	138,010	10.26	8
9	Activity Director	2,031	2,136	21,222	9.94	9
10	Activity Assistants	5,847	6,357	54,434	8.56	10
11	Social Service Workers	6,533	6,743	58,330	8.65	11
12	Dietician					12
13	Food Service Supervisor	2,731	2,877	19,582	6.81	13
14	Head Cook	9,529	9,873	65,152	6.60	14
15	Cook Helpers/Assistants	7,631	8,074	59,853	7.41	15
16	Dishwashers					16
17	Maintenance Workers	3,909	3,967	46,306	11.67	17
18	Housekeepers	19,637	20,774	135,371	6.52	18
19	Laundry	7,590	7,955	58,624	7.37	19
20	Administrator	2,024	2,180	66,821	30.65	20
21	Assistant Administrator	1,912	2,080	31,708	15.24	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,450	6,803	94,062	13.83	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,147	2,155	17,731	8.23	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	188,186	196,620	$ 2,050,221 *	$ 10.43	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

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B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 4,950	1-3	35
36	Medical Director	O	16,800	9-3	36
37	Medical Records Consultant	N	927	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	600	10-3	39
40	Physical Therapy Consultant	L	7,200	10a-3	40
41	Occupational Therapy Consulta	Y	7,200	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	569	11-3	44
45	Social Service Consultant	E	3,672	12-3	45
46	Other(specify)	S			46
47			0		47
48					48
49	TOTAL (lines 35 - 48)		$ 41,918		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

0

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
STELLA DURDLE	ADMIN		$ 66,821
LINDA WILLIAMS	ASST ADMIN		31,708
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 98,529

B. Administrative - Other

Description		Amount
CAREPLUS MGMT	MANAGEMENT FEE	$ 99,000
HUNTER MGMT	MANAGEMENT FEES	48,000
TOTAL (agree to Schedule V, line 17, col. 3)		$ 147,000
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
CAREPLUS MGMT	DATA PROC	$ 8,800
CAREPLUS MGMT	ADMIN CONSULT	132,000
HDSI	DATA PROC	1,315
AMERICAN DATA	DATA PROC	1,800
KBKB	ACCT	20,600
MEYER MAGENCE	LEGAL	3,082
SACHNOFF WEAVER	LEGAL	653
RICHARD PEELO	M/C COST REPORT	3,750
PERSONNEL PLANNERS	UNEMPL CONSULT	2,633
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 174,633

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 65,313
Unemployment Compensation Insurance	22,428
FICA Taxes	155,565
Employee Health Insurance	18,425
Employee Meals	12,004
Illinois Municipal Retirement Fund (IMRF)*	
PENSION/PROFIT SHARING CONTRIB	2,544
EMPLOYEE BENEFITS-OTHER	3,005
EMPLOYEE PHYSICAL EXAMS	0
INSURANCE EXECUTIVE LIFE	0
CHICAGO HEAD TAX	0
RELATED PARTY	0
INSURANCE EXECUTIVE LIFE	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 279,284

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,775
Health Care Worker Background Chec	867
(Indicate # of checks perform 61)	
ADV & PROMO/MARKETING	1,139
DUES & SUBSCRIPTIONS	5,204
LICENSES & PERMITS	550
TRUST FEES, CONTRIBUTIONS,etc.	207
MGMT CO ALLOCATION	1,282
LESS TRUST FEES, CONTRIB, etc.	(207)
Less: Public Relations Expense	( )
Non-allowable advertising	(326)
Yellow page advertising	(813)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,678

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	6,972
MGMT CO ALLOCATION	117
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,089

* Attach copy of IMRF notifications

**See instructions.

Print Preview

Facility Name & ID Num RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year			Amount of Expense Amortized Per Year								
	Improvement Type	Improvement Was Made	Total Cost	Useful Life	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PAINT/DECORATI	1998	$ 1,854	3	$	$ 309	$ 618	$ 618	$ 309	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 1,854		$	$ 309	$ 618	$ 618	$ 309	$	$	$	$

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